F

Referred To

MEDICAL PROVIDER'S STATEMENT

ONLY THE FOLLOWING MEDICAL PROVIDERS MAY CERTIFY DISABILITY CLAIMS: MD, DO, DC, DDS, DMD, DPM, Ph.D (in Psychology for psychiatric diagnoses), CNM, CNP

(Please complete all sections and be specific.)

PATIENT'S NAME Flavia Benitez SS#

Primary Diagnosis Lipoma of back ICD CODE

Secondary Diagnosis ICD CODE

COMPLETE THIS SECTION FOR PREGNANCY CLAIMS	EDC _____ NORMAL TO DATE? ☐ YES ☐ NO IF NO, PLEASE INDICATE COMPLICATIONS _____ IF DELIVERED, DATE _____ ☐ VAGINAL ☐ C-SECTION

Name of referring Physician, if applicable _____

Date symptoms first appeared/accident occurred 1-4-00

Is condition caused by or resulting from work ☐ YES ☒ NO

The result of a motor vehicle accident? ☐ YES ☒ NO

Date of first visit 1/4/00 Date of most recent visit 2/8/00 Next scheduled visit none

Frequency of visits: ☐ Weekly ☐ Monthly ☐ Other _____ (specify)

Has patient been hospital confined? ☐ YES ☒ NO If yes, when? From _____ to _____

Was surgery performed? ☒ YES ☐ NO Procedure _____ Date _____

Please describe in detail the PROPOSED TREATMENT PLAN (including therapy and all medications) and prognosis. Excision lipoma of back c revision of hypertrophic scar.

Please indicate any limitations or restrictions. _____

WAS/IS PATIENT CONTINUOUSLY AND TOTALLY UNABLE TO PERFORM REGULAR JOB DUTIES?

☒ YES ☐ NO If yes, when? From 1/27/00 through 2/14/00

(IF A DEFINITE ENDING DATE IS NOT KNOWN, PLEASE PROVIDE AN ESTIMATE)

ADDITIONAL REMARKS: none

CERTIFICATION

Carlos Fernandez-del Castillo, MD — 58466

MEDICAL PROVIDER'S NAME (PRINT) DEGREE/SPECIALTY LICENSE NUMBER

15 Parkman Street Boston MA 02114

STREET ADDRESS CITY/STATE ZIP TELEPHONE 617-726-5644

MEDICAL PROVIDER'S SIGNATURE [signature] DATE 2/8/00

DISABILITY MANAGEMENT SERVICES

Benitez EXHIBIT NO. 7 6/29/06